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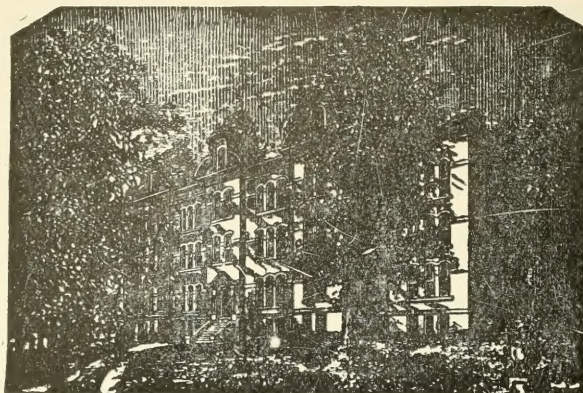
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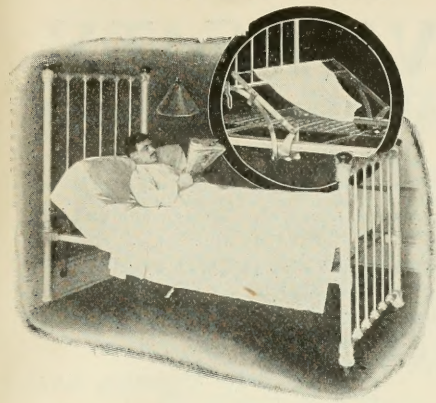
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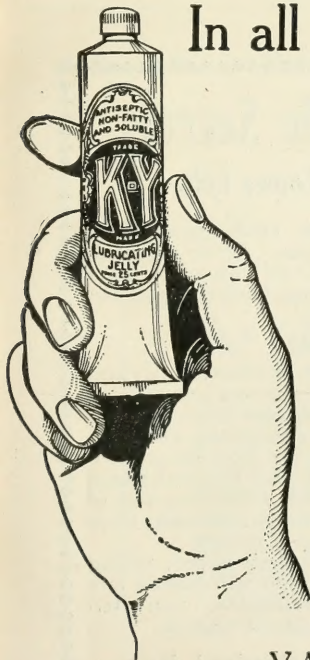
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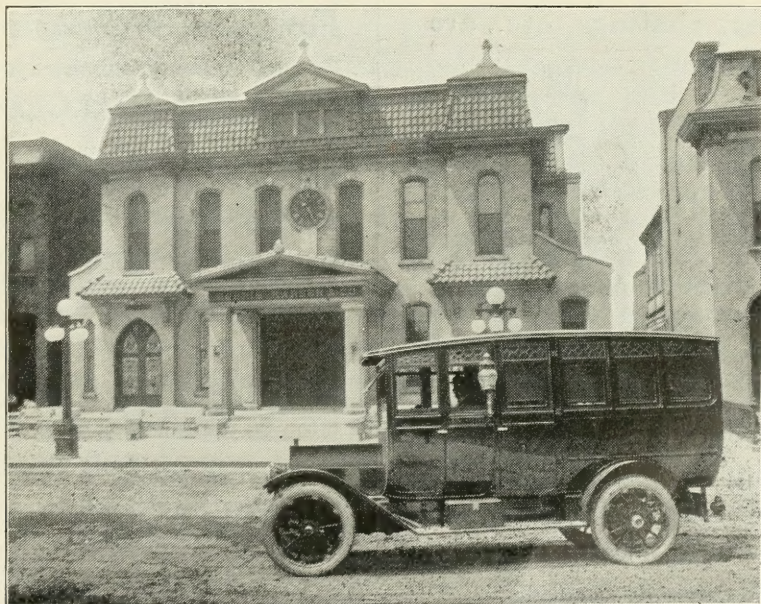
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NASHVILLE JOURNAL — OF — MEDICINE AND SURGERY

CHARLES S. BRIGGS, A.M., M.D., Editor.
W. T. BRIGGS, B.A., M.D., Associate Editor.

VOL. CX.

JULY, 1916.

No. 7

Original Communications

THE TWENTY-FIFTH ANNUAL REPORT OF SURGICAL OPERATIONS AT THE BRIGGS PRIVATE SURGICAL INFIRMARY.

Reported by

W. T. BRIGGS, M.D., NASHVILLE, TENN.

The following is the annual report of surgical operations performed at the Briggs Surgical Infirmary during the season extending from September, 1915, to August, 1916. Institutional treatment of surgical cases, as shown in this report, offers the best chances of success owing to systematic care, rigid asepsis, and organized discipline. In this report such cases have been selected as may present features of special interest to the general practitioner. Minor cases, of which there has been quite a large number, have been omitted. The success of the season has been more than usually marked. Only one death following operation has been recorded. In no instance has there been infection as the result of faulty technique. The infirmary adheres to the triple mixture known as the A. C. E. as the anæsthetic of choice, though straight chloroform has been resorted to without fear in cases demanding it. Morphia and atropia have been

administered in most cases as a preoperative measure of some importance. Post anæsthetic nausea has been troublesome in a good many cases whatever the anæsthetic agent. The Claudius iodine method of preparing catgut has been found eminently satisfactory. Much of the credit for the successful administration of affairs is due to Miss M. M. Sproull, now for over twenty years our efficient superintendent of nurses. The staff of nurses deserves commendation for excellent work and faithfulness in the performance of duty. Our thanks are extended to our friends of the medical profession for their much appreciated patronage and support:

Case No. I. Fecal Fistula Resulting from Appendicitis Operation. Miss J. R., æt. 20 years, Haglersville, Tenn., entered September 4, 1915. This patient had been operated on at her home during August, 1915, for acute appendicitis. The appendix was found gangrenous and perforated. There was quite a large quantity of pus, well walled off. A large rubber drain was used and evidently it caused a pressure necrosis in the cecum, for when removed one week later there was a discharge of fecal matter which has continued since. The patient entered the Infirmary for treatment. It was thought that the fistula would close in a short time under careful dieting and judicious purgation. There was some improvement for a time but the fistula refused to heal entirely. The patient went home October 30 with the fistula unclosed. However, it gave very little trouble and would only discharge at fairly long intervals.

Case No. III. Intra-Capsular Fracture of Left Hip-joint. Mrs. N. D. R., æt. 80 years, city, entered September 7. The patient was suffering from atheromatous condition of the cerebral vessels, having slight apoplectic attacks at intervals. During one of these attacks she fell upon the floor and sustained a fracture of the neck of the femur within the capsule. A light extension was applied, just enough to con-

trol the muscular spasms and sandbags used to steady the limb. The patient had had a serious burn across the hips a year ago and efforts to prevent bedsores were begun at once, but without success. The patient was fairly comfortable for three weeks when there ensued a series of light apoplectic attacks from which she would recover in a few hours, each attack, however, leaving distinct traces. Slight paralyses appearing, clearing up and reappearing. Aphasia developed and gradually grew worse. The patient died November 11. It is thought the diseased cerebral vessels would yield and dilate, causing pressure without actual rupture. The brain would then accommodate itself, the symptoms then improving, other vessels yielding, causing another attack. Softening of the brain ensued and the patient sank into a coma followed by death.

Case No. V. Hydrocele of the Tunica Vaginalis Testis. J. M. B., æt. 36 years, six miles Gallatin Pike, Davidson County, Tenn., admitted September 9th for treatment of large hydrocele of the right side of several years standing. The enlargement was painless, but was troublesome on account of its bulk. The light test showed translucency. The testicle was normal in size and was apparently healthy. Under A. C. E. anæsthesia, the day of admission, Volkmann's operation was performed, evacuating about six ounces of characteristic straw-colored fluid. The tunica vaginalis was sutured to the skin with continuous catgut suture and the parietal tunica of the two sides of the scrotum were approximated with through and through mattress suture of catgut. Recovery was rapid and satisfactory and the patient was dismissed two weeks after the operation.

Case No. VI. Internal Hemorrhoids. Mrs. A. E., æt. 42 years, entered September 12th for relief of internal hemorrhoids of long standing. The patient was 4-multipara and had suffered extremely in every pregnancy. The usual symptoms of protrusion, occasional hemorrhage and painful defe-

cation were present. Under A. C. E. anæsthesia, full dilatation of the rectal outlet was effected and five hemorrhoidal masses, ranging in size from a garden pea to a grape were brought into view. The larger piles were transfixed and ligated in halves and the smaller were ligated after Allingham's method. The bowels were evacuated by enema on the fourth day and afterwards daily movements were secured by purgatives. The results were perfect and the patient was dismissed on the tenth day.

Case No. VIII. Cervical Adenoma. Mrs. W. B. T., æt. 36 years, Springfield, Tenn., admitted September 17th with a glandular tumor the size of a goose egg on the left side of the neck beneath the sterno-mastoid muscle, the upper set of carotid glands being chiefly involved. Under A. C. E. an inch and half incision was made in the normal crease from just below the mastoid process downwards and forwards. The sterno-mastoid muscle was exposed and drawn forwards. The gland was then dissected out, a filiform drain inserted and the wound closed with continuous catgut. The wound healed rapidly but the induration persisted and subsided after a number of x-ray exposures.

Case No. IX. Ventral Hernia following Cholecystotomy. Mrs. W. G. B., æt. 39 years, Paris, Tenn., entered September 25th. This patient had been operated on during the last season for cholelithiasis and the usual drains used. Persistent vomiting for three days followed. The drains were removed in eight days and the wound had apparently healed nicely. The patient returned home, but soon began to complain of occasional attacks of pain across the lower costal region, and it was noticed that when she coughed there was a marked bulging at the site of operation, indicating the formation of a ventral hernia. For the relief of this condition she returned to the Infirmary. Under A. C. E. the old cicatrix was removed and the hernial sac freely dissected to the large hernial opening. The sac was opened

and omental adhesions released. The neck of the sac was closed with catgut mattress suture. The margins of the opening were pared and sutured with catgut. Wormgut sutures were placed through all the tissues to the peritoneum. The posterior sheath of the rectus was closed with continuous catgut. The rectus muscle was drawn outwards over the site of the hernial opening and anchored by a few sutures. The anterior layer of the sheath was sutured, after which the wormgut sutures were tied, closing the wound. Healing was perfect and the hernia was relieved, but the girdle pains persisted and at the end of three weeks decided paraplegia developed and progressed until the patient was entirely helpless. No cause could be assigned for this accident unless circulatory disturbances indirectly connected with the operation. Evidently the girdle pains were due to the spinal lesion, whatever its nature. The patient went home, and there being no improvement, was taken to another city, where the spinal column was opened without relief, and she died a short time after going home.

Case No. XI. Bassini's Operation for the Radical Cure of Inguinal Hernia. J. M. B., æt. 33 years, entered October 4th for radical operation for cure of right inguinal hernia. The patient had been the subject of hernia for a number of years and had worn a truss most of the time. The hernia was of the oblique variety and was complete. Under A. C. E. anæsthesia, Bassini's operation was performed, the sutures for the reconstruction of the canal being of kangaroo tendon. Intestine and omentum formed the contents of the sac. The skin was closed with continuous catgut suture and a compress and spica bandage used in the dressing. The parts healed without accident and the patient returned home in two weeks.

Case No. XIV. Recurrent Appendicitis. J. M. D., æt. 40 years, a travelling salesman from near Waverly, Tenn., admitted October 10th. This patient had had a number of at-

tacks of pain in the right iliac region which had been pronounced appendicitis, and from the fact that he was on the road most of the time he was apprehensive of having an attack at some point where he could not secure skilled surgical attention and he decided to have the appendix removed. Though some time had elapsed since an attack, examination elicited marked tenderness over the site of the appendix and upon deep palpation that organ could be felt. Under A. C. E. the appendix was reached through an incision four inches in length in the right semilunar line. The appendix was bound down by a narrow band about its middle which caused a marked angulation at that point. The appendix was freed, delivered, and removed. The stump was buried with catgut purse string suture. The wound was closed by serial sutures of catgut for the peritoneum and fascia and deep silk-worm gut sutures through the entire thickness of the parietes exclusive of the peritoneum. Recovery was rapid and uneventful and the patient was dismissed on the 17th day.

Case No. XV. Multilocular Ovarian Cyst. Mrs. J. R. G., æt. 72 years, Scottsville, Ky., entered October 15th. This patient had noticed a gradually increasing enlargement of the abdomen for over two years. The growth was painless but troublesome by reason of its size, presenting as large as a pregnancy at term with twins. The abdomen was dull on percussion over its entire area except at the sides, and fluctuation was not clearly elicited. Diagnosis, multilocular ovarian tumor. Under A. C. E. a five-inch median incision was made exposing the cyst. A Spencer-Wells trochar was introduced into the cyst but nothing came out. On withdrawing the trochar the contents of the sac was seen to be a thick colloid fluid and it was necessary to incise the cyst wall sufficiently to allow of the introduction of the hand with which enough of the contents could be scooped out to permit of the cyst being delivered. On withdrawal of the cyst the rather narrow pedicle was ligated with silk braid. The parietal wound was closed by suturing the peritoneum with contin-

uous catgut, then placing worm gut sutures through the entire thickness of the wall but not including the peritoneum. The patient made a remarkable recovery and was dismissed on the eighteenth day.

Case No. XVII. Laparotomy for Pyosalpinx. Appendectomy. Mrs. R. W. C., æt. 23 years, Paris, Tenn., admitted October 15th. This patient was suffering with severe pain confined to the lower half of the abdomen. Tenderness was present in both inguinal regions. Temperature and pulse not much disturbed. On vaginal examination a mass was felt on both sides of the uterus. Under A. C. E. a four-inch median incision was made in the median line. The right ovary was found cystic and the tube very much thickened. The left tube and ovary were matted together in a mass which was removed after ligaturing the broad ligament with linen ligatures. The right ovary and tube were also removed. The appendix was found thickened and adherent and was excised and the stump buried with purse string suture. The wound was closed with silk worm gut sutures after suturing the peritoneum with continuous catgut. The patient reacted well after the severe operation and after an uneventful convalescence was dismissed October 30th.

Case No. XIX. Curettage of the Uterus for Endocervicitis. Mrs. N. M., æt. 26 years, Louisville, Ky., entered Oct. 18 for relief of a protracted metrorrhagia accompanied by usual symptoms of endocervicitis. The patient had been under treatment by her home physicians for some time and was taken sick while on a visit to friends in this city. Under A. C. E. anæsthesia, the cervix was freely dilated, the uterine cavity thoroughly curetted, and after an application of iodine, packed with gauze. A large quantity of granular detritus was removed. Bimanual examination and the use of the sound eliminated the idea of fibroids, and it was concluded that the hemorrhage was due to the degenerated condition of the mucosa. After a week of treatment with ap-

plications of iodine to the cavity of the womb and glycerinated tampons applied to the cervix, the patient was dismissed.

Case No. XXI. Double Talipes Equino-Varus. Phelps Operation. E. M. T., æt. 2½ years, northern Alabama, entered October 22d. The patient had extreme talipes equinovarus in both feet. Phelps's open operation was done on both feet. The medio-tarsal joint was freely opened by incisions on inner border of the feet and all ligamentous and restricting bands divided. The feet were forced into over-corrected position. The wounds were packed with gauze and the feet were put up in plaster of Paris splints. Hemorrhage was unusually profuse but was controlled with the gauze packing. The splints were opened on the 12th day and the wounds found well filled with granulations. Healing progressed satisfactorily and on the 21st day light braces were adjusted. The deformity was entirely relieved and the patient was dismissed in four weeks.

Case No. XXIII. Varicocele. Excision of Veins. C. T., æt. 26 years, Springfield, Tenn., entered November 2d, was the subject of a large varicocele of the left side. The patient suffered with the usual discomfort of the condition and was oppressed with sexual hypochondria. He had used a suspensory bandage with only slight palliation. Examination showed a mass of veins in the left scrotum as large as a thumb and a somewhat atrophied testicle. Under A. C. E. the veins were exposed through an inch and a half incision, the mass carefully separated from the vas deferens and ligated above and below by strong catgut ligatures one inch apart and the veins excised. The stumps of the veins were then approximated by tying the ends of the distal and proximal ends of ligatures together. The scrotal wound was closed by continuous catgut suture. Rapid healing followed and the patient was dismissed in ten days.

Case No. XXIV. Bilateral Laceration of the Cervix. Mrs. L. C. M., æt. 31 years, Mansfield, Tenn., entered November 7th. The patient had suffered from womb disease for several years and had been curetted by her physician with only temporary relief. Examination disclosed a bilateral laceration of the cervix with the attendant inflammation which explained the persistence of the symptoms and the resistance to treatment given her at home. Under A. C. E. the clefts were pared after curettage and three sutures of No. 1 catgut on each side used to approximate the parts. Examination on the 12th day showed healing perfect. The patient was dismissed on the 21st day.

Case No. XXV. Urethral Stricture. J. M., æt. 33 years, Florence, Ala., admitted November 10th for relief of urethral stricture dating back to a severe gonorrhea contracted over ten years previously. The usual symptoms—painful and frequent micturition, straining during the act, constant gleety discharge and a gradual diminution of the stream until now the urine is passed in drops. The stricture was located just anterior to the bulbo-membranous portion of the canal. The smallest sound could not be passed and it was only after repeated efforts that a filiform guide could be introduced into the bladder. When this had been accomplished, under A. C. E., a Gouley's divulsor was passed over the guide into the bladder and its blades separated to its fullest extent. Nos. 17, 18, 19 sounds, Am. gauge, were successfully passed without difficulty. Sounds of large calibre were passed every other day for a week when the patient was dismissed with directions to use the sounds twice a week for some time.

Case No. XXVII. Single Harelip. D. R. M., æt. 1 year, Putnam County, Tenn., admitted November 18th, with a congenital harelip of the right side, the cleft extending through the lip nearly to the nostril. With chloroform anæsthesia, the day after admission, the lip was dissected from its attachments to the underlying parts and the cleft care-

fully pared so that union of the parts would make a projection instead of a notch. The cut edges were approximated with a harelip pin introduced at the junction of the skin and the vermillion border of the lip and the rest of the wound sutured with fine iron dyed silk. The parts were supported with carefully adjusted strips of adhesive plaster. The pin was removed on the second day and the silk sutures on the fourth. Healing was perfect and the correction of the deformity satisfactory.

Case No. XXVIII. Fistula in Ano. F. C. T., æt. 40 years, Gallatin, Tenn., entered November 22d for treatment of fistula in ano, following a perianal abscess caused by having been thrown on the pommel of a saddle while riding. The patient was annoyed by constant escape of flatus and persistent discharge of a thin, fetid fluid. Examination disclosed two orifices situated postero-laterally each about a quarter of an inch from the anus and from each other. The probe readily passed through one passage into the rectum and through the second one into the complete one. Under novocaine anæsthesia the fistulous tract was laid open into the rectum by incision upon a grooved director and the second fistulous channel incised into the main one. The tracts were thoroughly curetted and packed with gauze. Healing was satisfactory and the patient went home in two weeks with the parts nearly healed.

Case No. XXX. Fascial Sarcoma of the Thigh. D. K., æt. 62 years, city admitted November 30th for relief of a tumor over Hunter's canal on the left side. The growth was ovoidal in shape and was about the size of a cocoanut. He recalls having been struck at this point 18 months ago and one year later noticed a small, freely movable tumor under the skin, but as it was painless, he neglected it. A few weeks ago the swelling became painful and exhibited rapid growth. Under A. C. E. a seven inch incision was made over the long diameter of the tumor and the growth, together with as

much of the fascia as could be sacrificed, was removed. The gracilis muscle was spread over the tumor, requiring its division and the removal of its middle third. The fascia was closed over the muscles, and after placing a small drain at the lower angle, the wound was closed with continuous catgut. The wound healed rapidly and the patient was back at work in two weeks.

Case No. XXXII. Fibroid Tumor of the Uterus. Suprapubic Hysterectomy. Mrs. T. L. B., Arkansas, æt. 50 years, entered December 3d. This patient after passing her menopause gave a history of a gradual enlargement of the abdomen with frequent excessive metrorrhagia. Examination showed a marked enlargement of the abdomen produced by a clearly defined solid tumor about the size of an adult head. The growth was painless, hard upon palpation and was to some extent movable. The uterine probe discovered a marked increase of the depth of the uterine cavity. Under A. C. E. the growth was exposed by six inch median incision, through which the vessels were ligated and the womb and appendages removed. The stump of the womb was covered by suturing the edges of the broad ligament together from one side of the pelvis to the other. The parietal wound was closed in the usual manner. The tumor was a globular submucous fibroid involving the entire anterior wall of the uterus. Uneventful recovery ensued and the patient returned home three weeks after the operation.

Case No. XXXV. Chronic Appendicitis. Mrs. F. J., æt. 21 years, Hopkinsville, Ky., admitted December 11th. This patient had just recovered from a severe attack of appendicitis. Under A. C. E. the abdomen was opened by four inch incision through the right rectus sheath—Battle's incision. The tip of the appendix was readily located. The appendix six inches in length was buried behind the cecum and ileum, its distal inch only being free. The meso-appendix was secured with catgut and the appendix removed. The stump

was buried with a purse string suture. The parietal wound was closed as described in previous cases. The patient made an uneventful recovery and was dismissed December 27th.

Case No. XXXVI. Stone in the Bladder. Medio-Bilateral Lithotomy. F. D., æt. 12 years, Brush Creek, Tenn., entered December 14th with symptoms of vesical calculus. The cardinal symptoms of stone, frequent and painful micturition, itching and pain referred to the head of the penis, straining during the act were present. The introduction of the stone searcher at once discovered the presence of stone and manipulation with that instrument demonstrated fairly the size of the stone and its probable density. Under A. C. E. medio-bilateral lithotomy was performed and the calculus readily grasped and removed with the stone forceps. Hemorrhage was slight but a perineal tube and gauze was used to facilitate drainage. The tube was removed in twenty-four hours. The stone was ovoid in shape, of the oxalate of lime variety and was nearly an ounce in weight. The wound healed rapidly and the urine passed per vias naturales on the fourth day. The patient returned home two weeks after the operation.

Case No. XXXVIII. Recurrent Appendicitis. Mrs. R. M. A., æt. 48 years, Paris Tenn., admitted December 24th. A number of attacks of appendicitis at varying intervals from the last of which the patient was just recovering made an operation very necessary. On account of the fact that the patient was very corpulent an eight inch incision was made through the right rectus sheath. The extent of adhesions was unusual. The appendix was buried in dense adhesions and surrounded by pus. After removal of the appendix its stump was invaginated with purse string suture and the parietal wound closed in the usual manner. A rubber drainage tube was used. The patients condition after the operation was not good but she rallied after the persistent use of the Murphy drip for twenty-four hours. The drainage tube

was removed on the second day. The patient recovered slowly and was dismissed January 18th.

Case No. XL. Cholecystotomy. Mrs. J. F. D., æt. 52 years, Linton, Tenn., admitted January 8th. The patient was a large, fleshy woman, who had suffered greatly from pain in the region of the stomach, occasional icterus, frequent paroxysms of colic and great tenderness on perpendicular percussion over the gall bladder. Diagnosis, cholecystitis with probably gallstones. Under A. C. E., January 9th, the gall bladder was exposed through a six-inch incision along the outer side of the right rectus muscle and that organ found greatly distended. Only a small amount of fluid was evacuated with the aspirator and after the parts had been walled off from the general cavity by gauze pads, the gall bladder was incised and 214 stones about the size and shape of small beechnuts were removed. The ducts were carefully examined and found free of concretions. Rubber drainage was used, both in and by the side of the gall bladder and the wound closed by seriatim sutures reinforced by five silkworm gut sutures. The drains were removed on the 8th day, after which there was very little discharge, and the wound healed rapidly throughout its entire extent. The patient returned home, but in a short time began to complain of pain in the region of the operation. This continued for some time, when she was brought to the city and operated upon by another surgeon for carcinoma of the stomach and died from the effects of the operation.

Case No. XLI. Carcinoma Uteri. Mrs. J. S. E., æt. 51 years, Paris, Tenn., admitted January 9th. Mrs. E. had presented for treatment of carcinoma of the uterus in April, 1915, at which time it was found that the disease was too far advanced to admit of complete hysterectomy and the diseased cervix was removed as thoroughly as possible with ecraseur scissors and sharp curette. On her return on the above date, the vaginal vault was found occupied by a fun-

gating mass of carcinoma, which bled freely upon touch, and the disease was rapidly decimating the patient's strength. Under A. C. E. this mass was removed as far as possible with scissors and curette until apparently the entire uterus had been gouged out. The cavity left was packed with gauze and after a week the patient dismissed. Since her return home the patient's health has been variable, though for most of the time she has been able to go about.

Case No. XLIV. Gunshot Fracture of the Fibula. L. T., æt. 8 years, Craggie Hope, Tenn., entered January 23d. This little patient had received the ball from a 22 calibre rifle, the wound of entrance being about four inches above the external malleolus, the course of the ball ranging downwards. The ankle and foot were swollen and a radiograph was made showing the fracture of the fibula and the fragments of the bullet, two fragments had passed as low as the malleolus. The small missile had shattered into quite a large number of fragments and no effort was made to remove them.

The wound was dressed and an external lateral splint was applied, treating the case expectantly. There was no infection, the swelling subsided slowly and the patient was dismissed February 6th.

(To be continued.)

Selected Articles

THE CARE AND COMFORT OF THE SURGICAL PATIENT.

By A. C. L. PERCEFULL, Louisville, Ky.

The writer was prompted to choose this subject for a paper, because of the great neglect on the part of the surgeons of this one most essential part of the treatment of the surgically sick. Too little is written upon this subject in our text books and journals and spoken of in our societies. Too little stress is put upon it by teachers in our medical schools. Little or no attention is paid to it by many surgeons in their practice.

So many doctors are so eager to become surgeons before they have had experience enough with the sick to be able to distinguish between real and apparent suffering. So intent are they on their operative technique, that they think of nothing but the operation and lose sight of this one great essential—making the patient comfortable before, during or after the operation.

The sooner surgeons or would-be-surgeons realize that there is more to surgery than the wielding of the scalpel, the sooner they realize that it is just as much their duty to make their patients comfortable as it is to operate upon them, the sooner will a great deal of unnecessary suffering and discomfort be relieved, that now goes by unnoticed or unheeded or through ignorance unrecognized.

In all probability nothing new will be mentioned in this paper. In all probability you who do surgery will say that you do all you can to make your patients comfortable. But, do you?

No, you do not. It has been my observation for a number of years that surgeons, either through indifference, negligence, or ignorance, or through fear of breaking some time-honored practice or custom in treating operative patients, omit much that might make their patients more comfortable. Some of these time-honored customs will be mentioned later.

Surgeons are too prone to say, "Oh, well, you know you must have some pain and you will necessarily be uncomfortable. Now just try to be patient, you are going to be all right, you are fixed up fine now." Then with this same feeling of satisfaction they go outside and tell the patient's family how successful the operation was, etc. This is done so much that the expression, "The operation was successful," has become universal, no matter what happens to the patient. Surgeons are too prone to lose sight of the fact that their patients are still human and subject to all the ills, discomforts, etc., to which the human flesh is heir—and then some.

The scope of this paper will not include any surgical procedure or technique, save such as might bear upon the comfort of the patient. By comfort we wish to imply both mental and physical, for we feel that they go hand in hand or at least one often has an influence upon the other.

The surgeon's duty to his patient does not begin when he takes his scalpel in hand, nor does it end when the operation is completed. For the sake of convenience we will take up the three stages in which the surgeon is called upon to care for operative patients.

First, the pre-operative stage.

Second, the operative stage.

Third, the post-operative stage.

In the first stage we desire to call your attention to a few things that are often or nearly always neglected. Just as soon as an operation is decided upon, the surgeon's duties have just begun. It is in this stage that so much can be done to relieve the patient's mind and anxiety, thereby aiding the successful outcome of the case. Take the patient into

your confidence, talk plainly and freely with him, make him feel that you are interested in him. Do not boast of the number of patients and serious cases you have on hand, for he will know then that your thoughts and mind might be elsewhere, and that he might be neglected for some of the other very serious cases you have. You can show your patients that you are interested in them without making them think their case is terribly serious. Explain fully in a plain, clear way what you contemplate doing and what results you expect, at the same time assuring them that they will not be allowed to suffer unnecessarily and that everything will be done to make them comfortable, and then, keep your promise.

We feel that the patient's great fear is that of suffering and discomfort incident to the operation rather than the possibility of dying. Be frank and honest with them and gain their confidence, and you will add a great deal to their mental comfort. Study their eccentricities, their habits, as well as their general makeup both mental and physical. Try to learn of any idiosyncrasies that they may have. In the latter, the family physician can be of great assistance. Right here let me state that the physician should be kept in the case from the beginning to the end of the same. In the first place it is due the patients, for they have confidence in the family doctor. When their doctor is around their anxiety is relieved to a great extent. They have been accustomed to consult him when in distress and it is only natural that they would want him when about to undergo an operation. In the second place you might need him. He may be of very great assistance to you just for the reason that he probably already knows more about the patient than you will be able to learn during the whole time he is under your care. In the third place it is due the doctor. He should not be ignored as we have seen him ignored numbers and numbers of times.

If the patient is to be given a general anæsthetic, his condition should be fully explained to the anæsthetist. He should, if possible, visit the patient the day before the operation, to make his own physical examination, explain fully

about the anæsthetic so that he will not be frightened when the same is administered. If this is done we feel that the patient will have more confidence in the anæsthetist and not fear anæsthesia so much, for the fear of the anæsthetic is second to none, and incidentally we believe the anæsthetic fee will be paid more freely because he will feel that you have taken some interest in him and have done much to earn your fee.

The assistant also should not be kept in the background. He should at least be introduced to the patient, or better still he should, if possible, visit him with the surgeon and see his condition before being brought to the operating room. In the first place it is due the patient for two reasons. He should know all who are to take an important part in his operation, and then, too, suppose for some reason the surgeon is unable to visit the patient and do the dressing, etc., the assistant goes in an utter stranger, is compelled to explain that he is so-and-so's assistant and helped to operate upon him. This may be satisfactory, but still the patient not knowing possibly that there was an assistant may feel that he doesn't just exactly understand the case, etc., whereas, if he had met the assistant beforehand and knew that he was familiar with the case his anxiety would be much less.

Then, too, it is due the assistant because if he did not want the experience (and often that is all he gets) he would not be assisting anyone.

The operation should be discussed by the surgeon with the assistant, the entire procedure mapped out as nearly as possible so that the operation may be performed with smoothness and dispatch. This is doubly essential where a local anæsthetic is to be employed. The reason for this is obvious. There should be a thorough understanding so that as few words be spoken in the operating room as possible. Those of you who have been assistants know how seldom the above is done. It is useless to say that every minute of time saved in the operating room will aid in the successful outcome of the case.

It is hardly necessary for me to say that the patient should be relieved of all worry about selecting the room at hospital, making arrangements, etc. In this the surgeon can be of great assistance because he is usually familiar with the rooms, prices, etc.

And just here we wish to make a few remarks about hospital rooms. Did you ever lie flat on your back, alone most of the time, for hours, days, weeks and months possibly, gazing at four bare walls and the ceiling, with nothing to break the monotony? Of all the gloomy, lonesome, unattractive, cheerless places the average hospital room heads the list. Will not the hospitals ever realize that the more homelike and cheerful they make their rooms the better satisfied, contented and more comfortable will their patients be? We feel that it is time the doctors were demanding more cheerful surroundings for their patients.

After all arrangements have been made and your patient is settled in the hospital, certain preparations are necessary and usually carried out the day before the operation. Orders for these should be explicit and not general. Don't say, "Prepare patient for such and such an operation," but tell just what you want done. How often have we seen patients sent to the operating room with insufficient preparation or preparation that doesn't meet with your approval. In nine cases out of ten it is because explicit orders have not been given.

Do not lose sight of the fact that your patient's first night in the hospital is often and without exception, we believe, a very trying one. He is in strange surroundings, dreading more or less what the morning will bring and consequently he does not rest, and if he does not, what condition will he be in to undergo what is before him? How does a well person feel after not resting at all for a whole night? We think it is your absolute duty to see that your patient has some simple remedy to help him rest and sleep the night before the operation. We have, and so have you, seen this very thing, neglected time and time again.

We do not believe in thoroughly purging every patient, because this has a tendency to weaken him and we know it dehydrates the tissues and naturally increases the thirst, and anything that will increase post-operative thirst we know is harmful. It also has a tendency to increase postoperative distension. We believe that castor oil is the ideal cathartic.

We also feel that it is harmful to starve your patient before operation, as it has a tendency to weaken him, cause constipation and postoperative distension, thereby adding to his discomfort.

Having been properly prepared and given a good night's rest we bring him now to the second stage.

The first important thing to be remembered in this stage is "to be on time,"—don't for any preventable reason keep your patient waiting. Every minute you are late seems an hour to him. Don't fail to see him as soon as you get to the hospital, speaking an encouraging and cheerful word to him. It will increase his confidence and relieve the mind. By all means see that his physician is there.

If he is able, let him walk to the anæsthetic or operating room as the case may be; let him be as near normal as possible. See that everything is ready in operating room before starting the anæsthetic. If local anæsthesia is to be employed be sure that everything is ready and the procedure is thoroughly understood as far as possible by all operating room attendants. Avoid conversation and commotion as much as possible.

Just a word as to the anæsthetic. Of course, the anæsthetic should be selected such as will suit the case. It is questionable whether there is very much difference in after-pains of patients operated upon under local and those operated upon general anæsthesia, with the exception of quinine and urea hydrochlorid, the effect from which we know lasts for some time. As to shock, there is possibly a slight difference in favor of the local anæsthetic.

This we do know, that the general anæsthetic often causes great discomfort from nausea and vomiting. So it would

seem that where it is possible local anæsthesia should be used, for the comfort of the patient if for no other reason. Then, too, patients fear to be put to sleep. Add this to the fear of the operation and its outcome and it is easy to see why there is so much anxiety. If you can assure him that it will not be necessary to put him to sleep, you will tranquilize his mind, thereby add to his resistance which has much to do with the successful outcome of the operation. .

Now for the operation.

First of all the position of the patient on the operating table should receive more consideration than it does. It should be as natural as possible, yet in such a position so that the part to be operated upon is easily accessible. Try not to interfere with either respiration or circulation. See that no important nerves are unduly stretched and that pressure is taken off same. The table should be padded sufficiently thick to prevent pressure pains.

If the lumbosacral curve is very pronounced or the patient has prominent buttocks, a small pillow should be placed under the small of the back, by so doing you will relieve a great deal of the postoperative backache which is nearly always complained of. The same precaution should be taken about the head. A pillow should be placed under head of size corresponding to prominence of the shoulders.

If it is necessary to put him in any position that will violate any of the above precautions, do not maintain such position any longer than is absolutely necessary.

It is needless to say that the patient should not be "slopped up" in preparing the field of operation for obvious reasons.

As to the operation itself, will say very little except to call attention to a few precautions that will have a bearing on the postoperative comfort of the patient. It is needless to say that it should be done as rapidly as possible, consistent with thoroughness and with as little traumatism as possible to the tissues, exploring and handling the vital parts as little as possible.

See that sutures and ligatures are so placed that they will not include unnecessary tissue or pull in such manner as to cause pain. In closing your incisions see that the parts are not in an unnatural position, because when they assume the natural position there may be such tension on the sutures as to cause constant pain. In closing abdominal incisions, do not make such tension on peritoneal sutures, to do so is unnecessary and will cause pain, the same is true of the skin sutures, but the sutures in the fascia may be and should be put in with a little more tension, for this is the main layer in your closure, and tension here will not cause pain. Your duties are not ended with the closure of your wound. You should apply the first dressing at least. Do not leave this to an inexperienced assistant or nurse. This first dressing is very important. It should be put on with a view to comfort, supporting the parts, securing the dressing to the wound and should be done well. The dressing badly put on often causes as much discomfort and pain as the operation itself.

We are now approaching the stage which we will lay particular stress upon, not at very great length, however. It is in this stage that many surgeons otherwise brilliant and capable fail. Neglect of details in caring for the postoperative conditions has lost many patients. The postoperative treatment is just as essential and as important as the operative procedure, and oftentimes the successful termination of a case depends largely, yes nearly altogether, upon the after treatment. In this stage you are pretty apt to need the family physician. Have him anyway, for the chances are that the patient would rather see him than you. He will feel reassured after a visit from him.

The clothes, which are usually wet, should be removed and dry ones substituted. Patient is put to bed, which has previously been warmed by hot water bottles. He should have an attendant constantly at the bedside until he regains consciousness. This often is not done, but it should be. The surgeon should see that it is done. Just as soon as patient has fully recovered consciousness the chances are that he will

ask for water. Give him some, not all he wants, of course, but let him have water. Of all the cruel and inhuman things connected with surgery, the cruelist is to refuse to give a patient famishing, almost dying with thirst, water. Think of the human organism as an ever active chemical laboratory, then think of the havoc introduced into the orderly process of this intricate organism by flooding the tissues with anæsthetic poisons themselves, the manifold groups of changed secretions and cellular debris from this cause; now and then subtle poisons liberated or created by operative wounds and manipulations, then add to this baneful series by the stagnation of lymph flow caused by the deadly immobility of a supine posture. Thus having surcharged the tissues with abnormal secretions and imprisoned them more securely by the inhibition of muscular activity; add the final result of denying admittance to that well nigh universal solvent of effete abnormal secretion—water. Think of this, then wonder that the delicate human machine will survive such treatment. Take a well man and give him an anæsthetic for a half, three-quarters or an hour or longer, put him to bed, don't allow him to move and refuse him water, if you don't soon have a sick man, then miracles have not ceased. See that he gets water, if you leave it to the nurse she won't give it to him.

Suppose he does vomit, the chances are he would have vomited anyway. If you have done your surgery well and applied your dressings properly, then vomiting as a rule will do no harm. It is not in the scope of this paper to give treatment, but it goes without saying that vomiting should be relieved as much and as soon as possible. We do not feel that water given in moderation will cause dilatation of the stomach, as some contend. This much we do know, that water is one of the greatest diluents of poison in the system and it will help to get rid of the same by flushing out the kidneys and bowels and will also make the skin more active. Of course, there are cases, such as where the stomach is operated upon where anything by mouth is contraindicated, then

water can be given by proctoclysis. This relieves thirst very successfully. Give him water, and plenty of it—but you say you do. No, you don't. There are too many patients who have gone through this ordeal that will testify against you. It is needless to say that some opiate should be given to relieve pain, and something given to relieve extreme nervousness.

Then another thing that is not done, change of position. Nothing rests a tired, bed-fast person so much as change of position, and nothing tires one so much as maintaining the same position for a great length of time. Try it yourself. Oh! but you say, they must lie flat on their backs on account of the wound. Again let me say that if you have done your surgery well, and applied your dressings properly, changing the position sufficiently to relieve discomfort will do no harm. It will do an infinite amount of good.

The Fowler or modified position is oftentimes a relief and many times beneficial. Where there is vomiting it may relieve it. It is beneficial in diffuse peritonitis, or to confine peritonitis to the pelvis. This position is essential in old or debilitated patients.

Again, let us insist upon changing the position frequently. In abdominal cases a pillow under the knees will give great relief, as it relieves the tension on the abdominal muscles. When the patient is on the side, a small pillow placed between the knees prevents discomfort and pain, due to pressure of one knee against the other.

See that the nurse or attendant cares for the patient's hair, nails, mouth, teeth, and any little details of the toilet that will make him comfortable.

Find out the habits of patients, and if consistent, let him, as soon as possible, go back to them. If he is a smoker, let him smoke. In other words, don't subject the system to any more shock by withholding anything that it is used to receiving. Let the patient, as soon as possible, consistent with his condition, assume his normal life.

Let me repeat here, be prompt. When you tell a patient you will visit him at a certain time, do it if possible. Do your dressings at regular times if possible, for by so doing you will relieve your patient of a great deal of anxiety. Do not fail to have your assistant help if possible. It gives the patient confidence in him, so that if for any reason he should be called upon to care for the case, the patient will be better satisfied.

Be firm, but sympathetic. The surgeon who does not mix some sentiment with surgery, we feel, falls short of fulfilling his commission.

Pay attention to details, do not fail to do the little things that relieve your patient.

We all know how the laity feels towards surgery, and justly so, and it is high time that the surgeons were doing something to dispel this feeling. The best way to do that is to take such care of your patient that he will be more comfortable.

Of course, it is understood that all of the foregoing applies only to surgical cases in general, and not to any special case or condition. There are many more things that could be said upon this subject, and probably there have been things mentioned that could have been left out, but if this paper causes anyone of you to give more consideration to the comforts of a single patient, we will make no apologies for having taken up so much of your time.—*The Medical Brief.*

THE CANCER PROBLEM.

By CYRUS L. TOPLIFF,
New York City.

Cancer is now recognized as being one of the most dangerous and unfathomable diseases ever known.

The most skilled physicians have made a deep and scientific study of the disease for many years and yet no tangible progress has been made, and at the present time no more is known about its fundamental cause, or its cure, than a hundred years ago.

There are only two possible remedies now recommended by the medical profession; one is to destroy the diseased tissue by the use of radium, X-ray or heat, and the other is to remove it by a surgical operation in its earliest stages, and even then these treatments seldom secure a permanently favorable result, except in the earliest stages and in certain varieties.

When the disease is far advanced, either of these treatments may result in very serious effects, by the poison being conveyed through the blood circulation to other parts of the body where there may be a certain form of unhealthy tissue, which would furnish just the proper medium for its continued development.

As the disease often is not cured by medical treatment, and is seldom permanently cured by any surgical operation, it is quite evident that the medical profession will have to include entirely new lines of research in order to meet with a substantial success.

It is, therefore, a matter of profound satisfaction that the master minds in research work the world over are centering their efforts in this direction more intensely than in any other, and ere long a cure will surely be found.

Medical statistics show that during the year 1915, in the United State, 80,000 deaths resulted from this disease and of this number 67,000 were over 45 years of age.

The highest medical authorities have finally decided that cancer does not result from a germ of any kind but from some unknown form of bodily poison which starts and spreads through unhealthy or diseased tissue suited to its propagation, and ultimately destroys that tissue. Another point on which they agree is that the disease is not hereditary or contagious. This information will greatly relieve the minds of many thousands of people who, if the disease has previously existed in any branch of their family, are in constant fear of it, which very thought is a powerful factor in helping to create a cancerous condition. It has also been decided that the fundamental lesion may be present in the body for many years before the disease becomes fully developed, or the person is aware of its presence.

Perhaps the following suggestions may be worthy of consideration:

Without the mind, the body is only material matter, and therefore its conditions are largely, if not entirely, under the influence of the mind. If the medical profession will make a thorough scientific study of the relations between the mind and body, they will soon discover the fundamental cause of many diseased conditions which are at the present time a mystery.

Good thoughts induce good health, but bad thoughts, such as worry, fear, hate, spite, never fail to leave an injurious effect on the body by weakening the whole nervous system; and intense, long continued fear often attracts into manifestation the thing so dreaded.

It is impossible for cancers, tumors, tuberculosis, or any form of ulcerations to occur in any part of the body unless unhealthy or diseased tissue is present to form the necessary base for their propagation.

It is also impossible for said tissue to become diseased or unhealthy unless the nerves supplying life and action to that particular part of the body have first become impaired, so that they are unable to fulfill their natural functions.

As the mind is the leading power which can overstrain or weaken the nervous system, it is reasonable to suppose that we must first study the action of the mind over the body before we can discover the real fundamental cause of any inflammatory or malignant form of disease.

Fear and worry are synonymous, and inseparable in a person's mind. Therefore, fear is really the fundamental cause of many diseases, and the various forms of such depend largely on what particularly harmful thoughts are combined with fear in each patient.

If the medical profession fail to solve this difficult problem, it is possible that some "layman," who has given much thought and study to the subject, and experimented on scientific lines, may ultimately succeed in demonstrating the fundamental cause, and if it can be accomplished, then much of the mystery of all diseases will disappear and health and happiness will be much more general than at the present time.

Extracts from Home and Foreign Journals

SURGICAL

COLD ABSCESS OF TONGUE.

Venot and Arnould, *Gaz. Hebd. des Sciences Med. de Bordeaux*, Dec. 12, 1915. The patient was a man of fifty with laryngeal and pulmonary tuberculosis. The tumor was first noted in May and had enlarged to the size of a hen's egg. There were several small lymph nodes on the same side of the neck and one had suppurated on the opposite jaw. On evacuation, the pus showed tubercle bacilli but no growth was obtained from cultures. Several punctures were made followed by injection of iodoform in ether, the tumor now being of the size of a small nut, sclerotic and probably cured. —*Buffalo Medical Journal*.

CHOLECYSTITIS.

B. F. Zimmerman, in the January issue of the *American Journal of Surgery*, discusses the diagnosis and surgical treatment of cholecystitis.

Clinically the diagnosis of cholecystitis is not always easy. The classical symptoms—pain, vomiting, and icterus—may be absent. The last—jaundice—is usually late and points to obstructive lesions. Epigastric pain with tenderness over the gall bladder are important. Muscular rigidity is usually indicative of distension of the gall bladder. Of course, the history of preceding attacks is always helpful. To be sure of the diagnosis, it is necessary to exclude the commoner conditions as gastric and duodenal ulcer, appendicitis, kidney, and ureteral calculi, dermoid cysts and even extrauterine pregnancy.

In the surgical treatment of cholecystitis, there is a wide difference of opinion. Mayo holds that in cases where there is little damage to the gall bladder walls even in the presence of calculi, 90 per cent may be cured by removal of the stones and drainage of the gall bladder. When the mucosa of the gall bladder wall is extensively damaged, cholecystectomy is the better procedure. Mayo also claims that in 50 per cent of the cases which are drained and no stones found a recurrence of the gastric symptoms takes place in a few months. From the foregoing it is apparent that cholecystectomy is the preferred procedure in the absence of stones.

"Recurrent gall stones," the author thinks, are due to calculi overlooked at the original operation.

Under no circumstances should cholecystectomy be performed during an acute attack of cholecystitis with or without calculi.—*Medical Review of Reviews*.

BLOODLESS OPERATION FOR HEMORRHOIDS AND INCOMPLETE RECTAL PROLAPSE.

This operation comes from somewhere in France. The author is Major McKelvey Bill, M.D., and it is reported in the British Medical Journal for March 18, 1916.

The operation is indicated in cases in which four or more large piles occur and in mild grades of prolapse; in other words, it is indicated where a Whitehead operation is indicated, but has the advantage of being almost bloodless and less liable to complications.

Operation—After dilatation of the sphincter, a long silk suture is passed through the junction of the skin and mucous membrane in the mid-perineal line. This is left untied and is used as a tractor; two similar sutures are passed on either side, so that when traction is made on all three the extruded mucous membrane is converted into a triangle. Each side of the triangle is dealt with separately. The portion between two tractors is clamped to mark the area for excision, taking care to remain above the sensitive area. On

removing the clamp a furrow is left in which the suturing is done. Two Hagedorn needles are threaded at either end of a continuous silk suture. The first stitch is placed at the beginning of the furrow and tied in the middle of the thread. The two needles are then passed through from opposite sides at the same point—a cobbler's stitch. Each stitch is pulled taut, but not tied. The suture is continued in this manner at $\frac{1}{4}$ -inch intervals, until the end of the furrow is reached, where it is tied. With the scissors the redundant tissue is now cut off 1-16-inch from the suture line. The narrow ridge left is lightly touched with the thermo-cautery. The other two sides of the triangle are similarly treated, and the tractor sutures removed.

An opium suppository gr. 7 extr. opii, is inserted, and a rubber tube (3-8 by 3 inches) wound with iodoform gauze and well smeared with vaseline. This is left in situ until the morning of the fifth day post op. Bowels are kept constipated with opium and liquid diet for four days. At beginning of fifth day 1 oz. castor oil is given, and four hours later 6 oz. warm olive oil is injected through the tube, which is then gently removed. In a series of twenty-one cases this operation has given satisfactory results.—*Pacific Medical Journal*.

FLAPLESS AMPUTATION.

The method which gives the best chance of life to the patient is that which leaves the nutrition of the stump unimpaired to the end; in which, in other words, the nutrition is not cut off by the undermining of flaps; and now, after nearly two years experience, Fitzmaurice-Kelly considers gaseous gangrene as an absolute indication for a flapless amputation. Other conditions for which he employs the method, though for different reasons, are certain cases of compound comminuted fractures and of multiple wounds. The advantages claimed for this method are: That it saves life; that it saves length of limb; that the risk of secondary hemor-

rhage is lessened; that it arrests the spread of infection, whereas in flap amputations sepsis often recurs in the flaps, and spreads up from their base; and that it is possible where no other method is possible. As to the technic: the skin and deep fascia are divided, usually in circular fashion, but sometimes more skin can be gained by making the incision oblique; after retraction has occurred the muscles are divided at the level of the retracted skin—not too quickly, so as to allow a retraction of the layers; then the bone is sawed flush with the muscle; vessels are secured and nerves carefully shortened. The surface is slightly concave at first if the operation has been done properly, but soon becomes convex from further retraction. This, however, once the face is fairly clean, is overcome easily by extension. Strips of strapping are laid up the limb to the joint above, fixed with circular bands, and then carried down to a large ring of malleable aluminum to which a weight extension is attached. In the middle the stump is easily accessible for dressing. In this way all that has been lost by retraction can be regained rapidly, and it is rarely necessary to do more than remove a length of bone with a Gigli's saw.—*The Journal of the Am. Medical Association.*

NEPHROPEXY.

R. H. Gilpatrick says that our study of the anatomy and physiology of the kidney and its means of support lead us to the conclusion that the organ is never a fixture and that mobility without symptoms may exist to a marked degree. It is therefore neither wise nor necessary to attempt to fix a pathologically movable kidney in its exact anatomical position, an approach to within one inch being safe and sufficient, as well as much easier of accomplishment. The technique of various operations is given, with reports of cases, and the writer makes a general summary of his position as follows: A mechanical problem is best solved under good mechanical principles. Success is dependent upon the de-

gree to which normal anatomical and physiological conditions are approached. The kidney may not be wounded, fixed or constricted with impunity. Decapsulation, either partial or complete, does not impair kidney function. The most rational method of securing the kidney in position after it has become a wanderer to such a degree as to demand operation, is that of removing the cause and aiding in the reconstruction of natural support. Any permanent artificial support is dangerous if not completely destructive to the kidney's functional activity. The rolled-up and trans-fixed capsular flap offers a perfectly adequate hold for one end of the anchorage, and the muscular and fascial layers of the loin the same for the other end without sutures which emerge through the skin. If the anatomical relations of the kidney can not be permanently readjusted without destruction of its fundamental activity it deserves to be either let alone or removed.—*Medical Record*.

MEDICAL

THE USE OF BOILED MILK IN INFANT FEEDING.

Dr. Joseph Brennemann, of Chicago, read this paper. He stated that the use of boiled milk in digestive disturbances was quite general and if it was good for the sick baby there seemed no reason why it should not be good for the well baby. The advantages of boiled milk were both bacteriological and physiological. The bacteriological advantages were understood by all. The physiological advantages depended upon the difference in the coagulability of the casein in boiled and raw milk. Boiled milk formed very hard curds which could only be broken up by peripheral digestion. In some instances the curds in raw milk were so large and so hard that they could not be gotten rid of even by vomiting. One of the reasons for the good results obtained with *eiweiss* milk was that it formed almost invisible curds. One never observed bad results in changing a baby from raw milk to boiled milk

while the reverse was by no means true. The writer referred to the recent tendency to attribute all digestive disturbances in babies to the fats and carbohydrates in the food; he felt that the casein was also a factor in the production of symptoms of indigestion. The commercial pasteurization of milk was open to the objection that the milk was kept 24 hours after it had been pasteurized. Milk boiled at home was preferable to pasteurized milk; pasteurized milk might be considered as belonging in the raw milk class. If milk boiled at home was as popular as pasteurized milk there was every reason to believe that babies would suffer less.—*Medical Record*.

MEDICAL TREATMENT OF DIABETICS.

The material for Berkman's report was drawn from the histories of the patients operated on in the Mayo Clinic during the past year in whose urine the presence of sugar was positively demonstrated. The purpose was to establish a method of determining the operability of such patients, and reasonably rapid and safe course of treatment preparatory to and after operation. The first object was to render the patient's urine sugar free as soon as possible; and for this no better procedure was found than that advocated by Allen. The use of sodium bicarbonate has become routine; and, Berkman and his associates feel that it has contributed in no small degree to the recovery of their patients. It is used in dram doses by mouth six to eight times daily, three or four days before the operation. This treatment is resumed as soon as possible after operation. Should the surgeon find it necessary to give rectal salines, soda is administered in this way also. They have on two or three occasions found it advisable to give it by intravenous injections in 5 per cent solution. During the postoperative observation the urine is watched carefully, although keeping it free from sugar is more difficult, and is not as important as before operation. Twenty-six glycosuric patients came to operation. Two pa-

tients died, a mortality of 7.7 per cent. Eight patients were passing less than 10 gm. of sugar in twenty-four hours on an ordinary diet; and, other conditions being satisfactory, they required very little preoperative treatment, and that largely for the purpose of observation.—*The Journal of the American Medical Association.*

OCCULT BLOOD IN THE STOOLS.

Gregerson tabulates the findings as 147 patients supposedly free from ulceration in the digestive tract were examined. The subjects were the inmates of the medical ward, examined without discrimination. The ages ranged from a few months to 87 years. The diet in twenty-eight cases had included meat within a few days and the findings were constantly positive in this group. In the 1,310 specimens from 147 patients who had had no meat within four or five days, the findings were constantly negative in all but eighteen. Even in this group the reaction was negative in most of the tests. The diet must not contain meat, but milk, butter, eggs, fruit, bread, potatoes, tea, coffee and cocoa and also well cooked fish do not modify the response. As the various patients had been taking different drugs, the constantly negative reaction confirms that certain drugs do not affect the response to the test; namely, bismuth, iron, arsenic, mercury, barium sulphate, salicylic acid, tannalbin, antipyrin, hexamethylenamin, camphor, senna, and castor oil. None of these drugs or their derivatives seemed to modify in the least the response to the test. His comparative study of the various technics for determination of occult blood in the feces confirmed the superiority of the benzidin test. It is far simpler and quicker, while it is fifty times more sensitive than the Weber or other technics. This test applied to scraps of feces taken as far apart in the stool as possible gave always the same findings, confirming the regular blending of the feces throughout. Ingestion of four doses of 0.3 gm. blood, each, was followed by a positive response to the ben-

zidin test without fail. The benzidin solution must be made fresh each time, dissolving 1 per cent pulverized benzidin in equal parts glacial acetic acid and hydrogen dioxid. Ten or twenty drops are then dropped on the thin layer of feces on an object glass. In less than a minute a green, bluish-green or blue tint appears in case of positive findings, and the tabulated data confirm the clinical importance of a positive response.—*The Journal of the Am. Med. Asso.*

OBSTETRICAL

THE TREATMENT OF PUERPERAL SEPSIS BY UTERINE SUCTION AND DRAINAGE.

Norman Porritt is of the opinion that the suction tube has all the advantages with none of the dangers of the uterine douche. In at least two cases he has seen the uterine douche convert a smart sapremia into a rapidly fatal general infection, while in another case it set up acute fatal general infection, while in another case it set up acute, presumably chemical peritonitis. While he was administering the douche the woman was seized with agonizing abdominal pain, which was quickly followed by general collapse and rapidly developing abdominal tenderness and distention. The douching was at once stopped, but the patient died five hours after the onset of the acute pain. To illustrate the patulousness of the fallopian tubes, Dr. Goodall narrates a case of congenital atresia of the sigmoid. The abdomen was markedly distended, and dark liquid blood was coming in spurts from the vagina. On operating the abdomen was found full of blood and meconium, the sigmoid having ruptured. At the autopsy, four hours later, the blood was still coming from the vagina. In the cadaver Dr. Goodall has injected methylene blue into the uterine cavity with douch can and canula, imitating as closely as possible the technique of operative work. With a pressure of only two feet of elevation, and in some cases only eighteen inches, and with a temporary ob-

struction to the outflow, such as is frequently caused by clots and fragments of tissue, he was able to send fluid into the peritoneal cavity through the fallopian tubes. Hence, he says the risk of chemical peritonitis, not to speak of septic peritoneal contamination. Uterine suction tells us the conditions in the interior of the uterus. It is most instructive to watch the gradual alteration of the stuff withdrawn from a thick offensive fluid, loaded with semi-solid purulent masses, to a clear red liquid, and from that to an inoffensive mucus. Moreover, it prevents us from being misled, as we doubtless often are, by the deceptive character of what we find upon the diaper. The diaper may be covered with discharge, which may be only an overflow, as it may not come from the penthouse in the uterus at all, for there may be odorless discharge on the diaper, and foul, fetid fluid in the uterus. And efficient drainage of the uterus is the key to the successful treatment of puerperal sepsis.—*Medical Record*.

NATURE OF LOWER UTERINE SEGMENT.

Tweedy points out that the cervix is a tissue which does not easily tolerate a stretching force. If the elongated cervix of prolapse were really a process of stretching it would be pulled thin as a piece of twine; instead, it remains of normal thickness, no matter how greatly it is strained. We must then conclude, he says, that the cervix is not a stretchable structure but, on the other hand, that it has a power of extraordinary rapid growth when stimulated by continuous pressure. In a case reported by Jellett a small cervical stump left after the performance of a subtotal hysterectomy was firmly stitched to the aponeurosis of the abdominal wall in an effort to cure prolapse. It remained fixed in this position, but prolapse recurred and it was of so extreme a nature that the os protruded for many inches through the vulva. This enormous elongation was not accompanied by diminution of its diameter, but rather the reverse, and in this instance the increase of the cervix must have amounted to

about fifteen times its original size. Further, the vaginal portion of the cervix when not subjected to pressure does not enlarge.—*Journal of the Amer. Med. Asso.*

IS SYPHILIS HEREDITARY?

E. Kilbourne Tullidge (Detroit Med. Journal): The majority of modern biologists disbelieve in the transmissibility of acquired characteristics in general, which include disease and deformity. Mammalian ova have not been shown to be phagocytic and Gartner has definitely shown that spermatozoa are not. Hohlff and Gartner have calculated the number of spermatozoa in an ejaculation at over 26,000,000. (Note: The editor reported in the New York Medical Journal, June 4, 1910, three counts by hæmocytometer, respectively 346 million, 2,672 million and 286 million.) Owing, possible to missprints, we are unable to follow the mathematic argument as to the probability of true hereditary infection of the ovum, but it is extremely small. Colles' law as to the possibility of non-infection of the mother of a syphilitic child is no longer held to be true. Various experiments are cited as to the possibility of infection through the placenta, hence locating primarily in the liver of the fœtus, according with actual observation. Even if syphilis were hereditary, the mother would also be infected from the fetus.—*Medical Progress.*

Editorial

PUBLISHER'S NOTICE—The Journal is published in monthly numbers of 48 pages at \$1.00 a year, to be always paid in advance.

All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

Business communications, remittances by mail, either by money order, draft, or registered letter, should be addressed to the Business manager, C. S. Briggs, M. D. corner Summer and Union Streets, Nashville, Tenn.

All communications for the Journal, books for review, exchanges, etc., should be addressed to the Editor.

PELLAGRA.

The Pellagra Commission of Nashville, headed by Dr. Jas. W. Jobling, has recently published a very interesting preliminary report upon the epidemiology of pellagra. The work done has been thorough in every detail and shows an immense amount of clerical, as well as field work. It also impresses one very forcibly with the fact that pellagra is constantly on the increase and that this increased incidence is not merely due to better methods of diagnosis, but is actual. So far as the causal relation of insufficient proteins to the disease is concerned, the report shows that apparently there is nothing specific about this. The lowered vitality resulting from poor food simply allows the disease to get a foothold. It also rather explodes the theory that the disease is due to large amounts of colloidal silicates in the food and water and is curable by use of lime salts, since most of the pellagrins considered obtained large amounts of lime salts in their water. There seems to be absolutely no relation between the kind of water used and the disease.

The most important point brought out is the greater incidence of this disease in the unsewered parts of the city and the apparent contagiousness of the disease, since many instances are given to show how several cases would develop shortly after a pellagrin moved into a given locality, espec-

ially if there were open privies and unscreened houses in the neighborhood. Furthermore, certain houses seemed to be the point of origin of the disease in several instances. For the most part the greater number of cases of the disease were found in the outlying districts where there are no sewers, where very few houses are screened and where the privies are filthy and close to the houses. Typhoid fever, which is rather common in Nashville, was found to occur oftener in the same localities where pellegra exists.

As this is only a preliminary report no theories were advanced in regard to the epidemiology. To the reader, however, the impression comes that pellagra will be added to the list of infectious diseases.

The work done by the commission will do much toward educating the laymen in regard to the close relationship between filth and disease, and we hope it will also awaken the public conscience to such an extent that the sewerage system of Nashville will be extended, the open privy abolished and screening of houses made compulsory.

W. T. B.

AMERICAN MEDICAL ASSOCIATION.

The meeting in Detroit, Mich., this month, with an attendance of about 5,000, was full of interest throughout. New York City was selected as the next place of meeting, and the following officers were elected: President, Dr. Charles H. Mayo, Rochester, Minn.; vice presidents, Drs. Llewellyn F. Barker, Baltimore, Md.; John Leaming, Chicago, Ill.; J. H. Carstens, Detroit, Mich., and George F. Keiper, Lafayette, Ind.; secretary and treasurer, Drs. Alex. R. Craig and William A. Pusey, respectively, both of Chicago, and re-elected; chairman of House of Delegates, Dr. Hubert Work, Pueblo, Colo.; vice chairman of the House of Delegates, Dr. Dwight H. Murray, Syracuse, N. Y.; members of Board of Trustees, Drs. A. R. Mitchell, Lincoln, Neb.; E. J. McKnight, Hartford, Conn.; Oscar Dowling, Shreveport, La.; member of

Judicial Council, Dr. H. A. Black, Pueblo, Col.; member of Council on Health and Public Instruction, Dr. Frank Billings, Chicago, Ill.; member of Council on Medical Education, Dr. William D. Haggard, Nashville, Tenn.; member of Council on Scientific Assembly, Dr. J. Shelton Horsley, Richmond, Va.

Among the officers of the various scientific sections, the following doctors from this section were elected: Dr. Ernest C. Levy, Richmond, vice chairman of the Public Health and Preventive Medicine Section, and Dr. W. S. Rankin, Raleigh, N. C., orator for the same section; Dr. H. H. Hazen, Washington, D. C., secretary of the Section on Dermatology. —*Virginia Medical Semi-Monthly*.

AMERICAN EDITORS' ASSOCIATION.

The annual meeting, under the presidency of Dr. Edward C. Register, of Charlotte, N. C., will be held at the McAlpin hotel, New York City, October 25th and 26th.

ENGLAND WARS ON CANCER.

Central Midwives Board Issues New Circular.
Cancer of Breast Curable by Early Treatment.

That the policy of "business as usual" applies to constructive efforts for the prevention of diseases in England is evident from the publication by the Central Midwives Board as recently as March 16, 1916, of a new circular on cancer of the breast. The practice of midwifery in England and Wales is controlled by this board and the circular is the newest of a series issued for the instruction of all women practicing this profession and registered with the board as required by the law. The leaflet on cancer of the breast was prepared by the chairman, Dr. F. H. Champneys, F. R. C. P., and is distributed to the public as well as to midwives.

Pointing out that cancer of the breast, unless treated by early removal, always ends in death, Dr. Champneys states that the disease is at first only in the part affected and not in the system. "Every day and even every minute," the circular says, "is of importance and no time at all should be lost. The earliest symptom is a lump in the breast which is usually painless and may be quite small. It may remain without seeming to grow for some time. The only cure for it is early removal. Although it is often easy to be sure that a lump is cancerous, many lumps which begin by being innocent turn into cancer some times after many years."

Dr. Champneys advises that all lumps except those caused by undoubted and recent inflammation should be removed as soon as they are found and advises all women who discover a lump in the breast to consult at once a surgeon who is in the habit of dealing with them. If the lumps are not removed and are cancerous the disease sooner or later spreads through the body and becomes incurable, while if the lumps are not cancerous they may become so. "The removal of an early lump," the leaflet goes on to say, "is generally simple and if microscopic examination should show afterward that it was not cancerous a danger for the future will have been averted and the anxiety of the patient and her friends will be relieved." From such an operation there is generally "practically painless recovery in a few days. If the lump proves to be cancerous, however, a further operation is necessary, which, if undertaken early saves many lives."

According to Dr. Champneys, if women would follow the above advice much loss of life, many regrets when too late, and much misery would be saved.

DO YOU KNOW THAT

It's worry, not work, which shortens life?

A cold bath every morning is the best complexion remedy?

Poor health is expensive?

The U. S. Public Health Service has reduced malaria 60 per cent in some localities?

The death rate from typhoid fever in the United States has been cut in half since 1900?

Pneumonia kills over 120,000 Americans each year?

Flyless town has few funerals?

The well that drains the cesspool is the cup of death?

UNITED STATES PUBLIC HEALTH SERVICE.

Twenty-five out of every 1,000 employes in American industries, according to recent statistics, are constantly incapacitated by sickness, the average worker losing approximately nine days each year on this account. This "non-effective rate" for the great army of industrial workers in the United States barely suggests the total money loss to employers and employes. The lessened efficiency, the effects of reduced earnings in times of sickness, as well as the cost of medical attention, and the economic loss from deaths, swell the cost to industry and to the nation to almost incalculable figures.

That much of this loss is nothing less than preventable waste and that this waste can be largely reduced by a properly conducted system of governmental health insurance for wageworkers are conclusions set forth in Public Health Bulletin No. 76, containing the results of a study of "Health Insurance—Its Relation to the Public Health," just issued by the United States Public Health Service.

The preventive value of health insurance is given especial emphasis in this study. "Any system of health insurance for the United States or any State should at its inception have prevention of sickness as one of its fundamental purposes," says the bulletin. "This country should profit by the experience of European countries where prevention is being recognized as the central idea necessary to health insurance if health insurance is to attain its greatest success in improving the health and efficiency of the industrial population."

Such a system, it is pointed out in the bulletin, would

1. Provide cash benefits and medical service for all wage-earners in times of sickness at much less cost than is now possible. Adequate medical relief would thus be placed within the reach of even the lowest paid workers who are most subject to ill-health.

2. Distribute the cost among employers, employees, and the public as the groups responsible for disease causing conditions and afford these groups a definite financial incentive for removing these conditions. This can be done by means of small weekly payments from employees, supplemented by appropriate contributions from employers and government at a rate reducible in proportion to the reduction of sickness.

3. Become an effective health measure by linking the co-operative efforts of the three responsible groups with the work of National, State, and local health agencies, and by utilizing these agencies in the administration of the health insurance system.

4. Afford a better basis for the co-operation of the medical profession with public health agencies.

5. Eliminate the elements of paternalism and charity-giving by making employees and the public, as well as employers, joint agents in the control of this fund.

"A governmental system of health insurance," concludes the study, "can be adapted to American conditions, and when adapted will prove to be a health measure of extraordinary value."

Reviews and Book Notices

Sajous's Analytic Cyclopedia of Practical Medicine—By Dr. C. E. de M. Sajous and One Hundred Associate Editors. Seventh Edition of Vol. VII. F. A. Davis Company, Publishers. Philadelphia, 1916.

This volume of over 800 pages attempts to review practically the latest scientific literature on the various subjects of medicine. These reviews are very practical and consist largely of the conclusions of authorities, without editorial comment, simply as the most advanced scientific conclusions up to date.

This volume is equal, if not superior, to the others in many respects. Among the many articles, that on opium condenses in twenty-six pages a complete outline history of opium and its alkaloids and the general uses they are put to, also its physiological action and pathological effects.

Morphinism is included in this, stated in the briefest way; also the facts that are really settled up to the present time, not the theories but the general opinion endorsed by the profession. It is by far the best summary of the facts that has been printed and will be studied with great satisfaction.

One peculiar value of this work is its chemistry and therapeutics of drugs and their action, as well as the latest surgical operations and the facts that are considered settled up to the present time and the evidence on which they are based.

This is more than a textbook and resembles a dictionary in the grouping and studies, particularly of the disputed questions of medicine. This volume deserves the warmest commendation and will be a very great help to all practicing physicians. Write to the publisher for descriptive circular.
—T. D. C.

Publisher's Department

“Robinson's Lime Juice and Pepsin” is an excellent remedy in the gastric derangements particularly prevalent at this season. It is superior as a digestive agent to many other similar goods. (See advertisement in this issue.)

MORE THAN A COINCIDENCE.

It was more than a coincidence that thousands of physicians stated in response to a recent inquiry that one of their most highly prized drugs was cactus. A few doctors might have so reported and the fact be attributed to personal prejudice, but when the same is vouchsafed by thousands of earnest practitioners, it must be believed that their verdict was based on actual observation and clinical experience.

There can be no doubt that Cactina Pillets fill a definite place in the management of cardiac disorders. No claim is made that these are to supersede the more powerful cardiac drugs, when these are properly indicated, but when it is desired to support and sustain the heart and strengthen and regulate its action, Cactina Pillets will not disappoint. Thus a great many physicians have grown to look on Cactina Pillets as one of the safest and most satisfactory cardiac tonics at their command. One to two Cactina Pillets every three or four hours will be found excellent—for example, for relieving the so-called “tobacco heart.”

SLEEPLESSNESS.

There can be no denying the fact that for all round use, the bromides still hold first place in the rational treatment of insomnia. Of course, especial care should be used in selecting the particular bromides to be employed, as the re-

sults accomplished obviously depend to a large extent on their purity and quality. This is well shown by the notable therapeutic utility of Peacock's Bromides, a preparation of bromide salts that for many years has been the first remedy turned to by countless discriminating physicians whenever a sedative or hypnotic has been needed. Particularly in overcoming the sleeplessness due to nervous excitation, neurasthenia, alcoholism, prolonged worry, hysteria, and so on, have Peacock's Bromides been found of never failing efficiency, with gratifying freedom from gastric irritation, and the all too evident drawbacks that so often characterize other hypnotic agents.

How much good has been accomplished since the adoption of "first aid" measures, the doctor realizes and often has occasion to admit.

Then, since surgical "first aid" is useful—both to patient and surgeon—why not Anodyne "first aid?" Bearing in mind that the doctor is not called in, as a rule, until the patient has become alarmed at his or her condition, after simple home treatment has failed to relieve, or is at the end of the ability to bear pain or discomfort, is it not better to depend upon Anodyne "first aid" instead of the dose of opiate, narcotic, or "coal tar" taken by the patient on his or her own responsibility?

Anodyne "first aid" refers, for example, to K-Y Analgesic. K-Y Analgesic makes Analgesia attainable by the use of an external application.

Being greaseless and water-soluble, K-Y Analgesic absorbs quickly, differing, therefore, in this important property, from grease or oil (the ordinary ointment or lotion bases).

It penetrates deeply, so that real analgesic effect is added to the property of counter-irritation.

It relieves promptly, and what is most important, its effect is generally prolonged.

Furthermore, being itself incapable of doing harm, K-Y Analgesic can be used at libitum and as often as necessity dictates.

It does not stain skin or soil clothing. It washes off quickly and easily.

For the relief of pain, such as neuralgia, headache, rheumatic, or to relieve soreness, such as in sprains, stiff joints, lumbago, etc., K-Y Analgesic will prove a reliable and useful anodyne "first aid" to keep the patient comfortable between the doctor's visits and to enable him to attain analgesia without having to use agents internally or hypodermically whose action might mark important symptoms or modify them so as to obscure or delay diagnosis.



Stanolind Trade Mark Reg. U. S. Pat. Off. **Liquid Paraffin**

(Medium Heavy)

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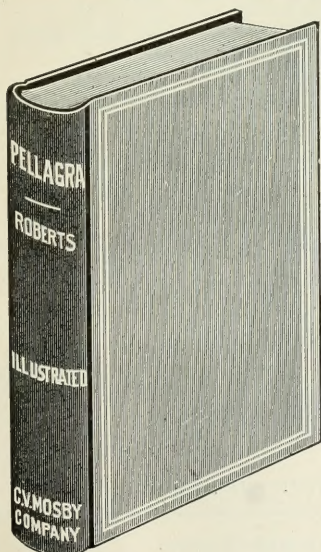
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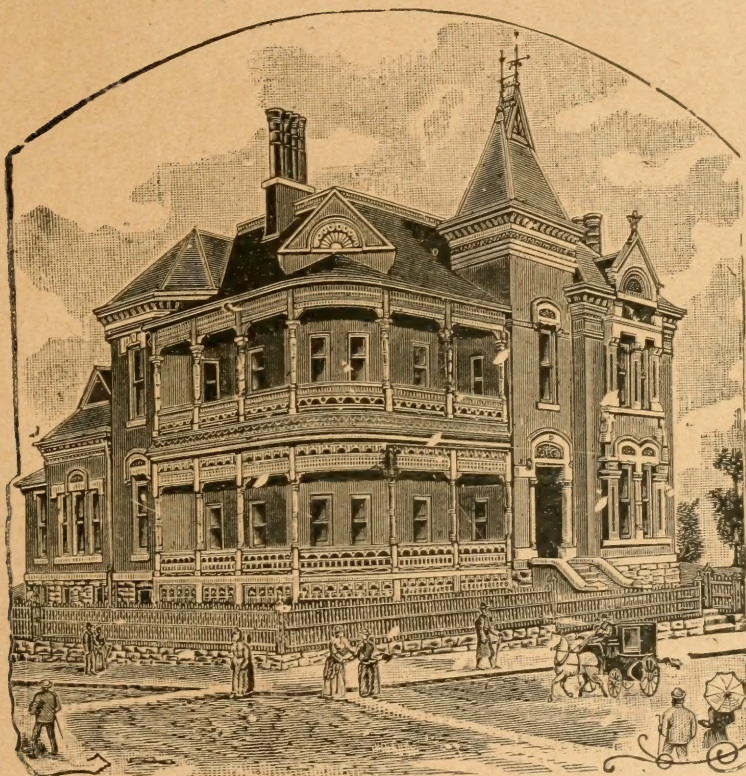
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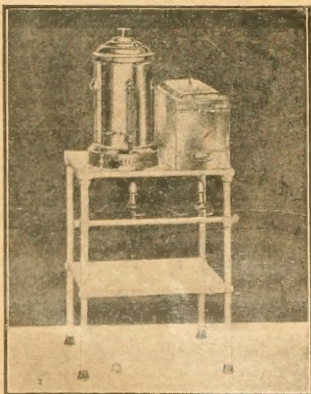
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